Editorials

Will Commercialism Destroy the Medical Profession?

THE "LEARNED PROFESSIONS" have always had a special place in our society. Traditionally, these have included the law, the clergy, medicine and sometimes the military. In present-day society a case may be made that some other professions may be thought of as learned, in that they profess a body of knowledge, are recognized by society as custodians of this body of knowledge and use it to serve the interests and welfare of others. In this sense the professions, especially the so-called learned professions, have been somewhat set apart, but now in a society that professes egalitarianism, the medical profession, at least, finds itself in a more difficult role. This societal egalitarianism has found expression in the current conventional wisdom that medicine is now everyone's business and that health care should be rendered in the open marketplace like any other business. Open competition has been introduced into medical practice and the delivery of health care, and the question may be asked whether medicine or any profession can survive as a profession in the face of what could be destructive competitive commercialism within its ranks.

First, it should be recognized that there has always been some commerce and competition in health care. Physicians and other health professionals must earn a living. Competition to enter medical schools is severe and the period of training is long and costly. True, some few physicians charge excessively and generate excessive incomes, but many more frequently give their services at less than cost, and in many instances in their own way they actually subsidize government programs for the poor and the elderly. Most are trying to take care of patients and to earn an honest living in what are often increasingly trying circumstances. Commerce and competition have always been there but, at least in recent times, professionalism has set the standards of commerce and competition to which most physicians have adhered.

But are we now to see the demise of professionalism and of a noble profession? This seems unlikely. There is more that should hold the medical profession together than there is dividing it. There is a rapidly growing science, which in one sense is fractionating the profession but also is making physicians more dependent on one another. A body of knowledge is a sine qua non for any profession, and certainly a learned profession. The body of knowledge in medicine is all one body and it is getting to be awesome. The concept of helping others runs deep in the medical profession and touches almost every physician in practice. It is a reason why many, if not most, of us entered the profession in the first place. And finally, all of medicine and all of the profession come together in addressing the health care and well-being of whole patients and of society as a whole. It is worth noting that none of this has anything to do with commercialism or competition or with the socioeconomics of health care.

Will commercialism destroy the medical profession? The answer has to be *no*. Rather the profession not only will survive, but it will become stronger, as quickly as it learns to develop and use its authority in science and its advocacy of patients effectively, in whatever may be the social, economic or political environment of health care—today, or in the future.

MSMW

Extraintestinal *Campylobacter* Infections

CAMPYLOBACTERS ARE NOW WELL-KNOWN CAUSES of a variety of intestinal ailments, but the first reported illnesses in humans due to these organisms were systemic infections.[1] It was not until 1957 that Elizabeth King found microbiologic diversity among these pathogens and noted that one group (now called *Campylobacter fetus*) caused systemic illnesses, whereas the other group (which includes what are now called *Campylobacter jejuni, Campylobacter coli* and other closely related organisms) chiefly caused diarrheal disease.[2] The development of selective methods for isolating these latter organisms from stool specimens[3] has led to their recognition as the most common bacterial causes of acute infectious diarrhea in the United States and other developed countries[4] and hyperendemic infection of young children in developing countries.

Patients with *Campylobacter* enteritis frequently have fever and other constitutional symptoms, and occasionally *C jejuni* causes extraintestinal infections similar to those originally described by King.[2-5] The consequences of these infections range from transient bacteremia, to localized infections including septic arthritis, meningitis, peritonitis, cholecystitis and abscesses, to a fulminant Gram-negative sepsis.[5] In the review by Dhawan and colleagues in this issue, several important clinical and epidemiologic points about *C jejuni* bacteremia are made. A much higher proportion of patients who have *C jejuni* bacteremia than patients with infection limited to the intestine are at the extremes of age or have an underlying disease. Although mortality occurs in such a skewed population, the 24% rate derived from the literature review by Dhawan and co-workers is probably a significant overestimate based in part on who gets cultured and then which cases are reported. That many of the infections resolved spontaneously or after treatment with erythromycin given orally further emphasizes the frequently benign outcome.

One wonders, then, why most *C jejuni* infections appear to remain confined to the gut and only occasionally to spread systemically. One possibility is that extraintestinal *C jejuni* infections occur more often than they are recognized. As pointed out by Dhawan and colleagues, blood cultures are rarely done in patients with febrile diarrhea. Often suitable media are not used nor are the proper incubation conditions for isolating these fastidious organisms,[6] which nevertheless are susceptible to many of the commonly used antimicrobial agents or require no treatment at all. Thus, it is likely that the true incidence of extraintestinal *C jejuni* infections is underestimated.

A second explanation for the infrequency of extraintestinal